PATIENT INFORMATION FORM
Please print and provide complete information for each line

First Name:_____ MI:____ Last Name:_____
Address:_____ City:_____ State:___ Zip:_____
Phone #:_____ Cell Phone #:_____Date of Birth:_____ Age:___
Marital status:_____ Social security #:_____ Sex:___
Email:_____

SPOUSE
Name:_____ SS#:_____ Date of Birth:_____
Employer:_____ Occupation:_____ Phone #:_____

Other Contact:_____
Relationship:_____ Contact's
Address:_____ Phone #:_____

EMPLOYER INFORMATION
Employer:_____ Address:_____
City, State, Zip:_____ Phone#_____ Occupation:_____

REFERRED BY: _____ Phone #:_____
Address:_____

FAMILY PHYSICIAN: _____ Phone #:_____
Address:_____

INSURANCE INFORMATION
Primary Insurance Co:_____
Policyholder name:_____ Date of Birth:_____

Secondary Insurance Co:_____
Policyholder name:_____Date of Birth:_____

FINANCIAL ASSIGNMENT AND AGREEMENT
Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance at the time of your visit.** I request the payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. If you do not wish to have us file with your insurance or you do not have medical insurance, then you agree to pay our Private Pay rate in full on your office visit. By signing below you are agreeing to the above stated information and that the above information is correct to the best of your knowledge.

Patient Signature:_____ Date:_____

REFRACTION SERVICE AND FEE

Refraction is the process of determining if there is a need for corrective eyeglasses or the eye's refractive error.

Refraction is an essential part of a complete medical eye exam, but is generally not considered a covered expense under Medicare and most managed care plans, such as HMO's and PPO's. Therefore, the patient is typically responsible for these charges.
The fee for refraction is $55.00 in addition to any co-payment applicable to your insurance plan. In the absence of a medical condition other than a refractive error, most routine eye exams are also considered a non-covered service under most medical insurance plans.

The performance of this refraction is determined solely by the doctor and may or may not be a part of the services provided to you today.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

PATIENT ACKNOWLEDGEMENT

I have read the above information and agree to pay Dr. Martin Reinke for all services that are not covered under my insurance plan in addition to any co-pays and deductibles.

_____ _____

Patient Signature Date

Name _____ Date _____

Age _____ HT _____ WT_____ Sex: ☐ Male ☐ Female Date of birth: _____

Race: ☐ African American ☐ Asian Pacific ☐ Caucasian ☐ Hispanic

☐ Native American ☐ Other:_____

Reason for today's visit:

_____

Do you wear glasses? Yes No Do you wear contacts? Yes No

Please circle all eye diseases you have been diagnosed with:

Cataracts / Retina Problems / Macular Degeneration / Glaucoma

Current Medications and dosage:

Drug Name	Dosage	Times per day

Do you currently or have you ever taken any prostate medicines such as Flomax: Yes No

if yes please list: _____

Drug Allergies:

◯ No known allergies ◯ Latex allergy ◯ Sulfa allergy ◯ Adhesive Tape

Medication allergy _____

_____

Surgical History: (List all surgeries you have had and the year)

_____

_____

Complications with anesthesia? Yes No If yes, please list**:** _____

Medical history: (including those you currently are treating with medications)

Diabetes: Yes No x____years Anemia: Yes No High blood pressure: Yes No

Check any of the following:

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back/Neck Problems
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chest Pain
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ ENT Problems
- ☐ GI Problems
- ☐ Glaucoma
- ☐ GYN Problems
- ☐ HIV
- ☐ Hard of Hearing
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type ____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney/Bladder Problems
- ☐ Liver Disease
- ☐ Other Psychiatric Problems
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Prostate Problems
- ☐ Restless Leg Syndrome
- ☐ Retina Problems
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Any other problems of concerns:

_____

FAMILY HISTORY:

Disease	Relationship to Patient	Disease	Relationship to Patient
Blindness		Heart Disease	
Glaucoma		Lupus	
Diabetes		Stroke	
Macular Degeneration		Thyroid Disease	
Cancer		Other	

Social History: Do you drink alcohol? Yes No Drinks per week _____

Do you smoke? Yes No Packs per day _____ x_____years

Previous smoker? Yes No Year quit _____

PATIENT RECORD OF DISCLOSURE

The HIPPA privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information (PHI). The individual is also granted the right to request confidential communication, or that a communication be made by alternative means.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply)

____ By home telephone, my number is _____

____ It is ok to leave me a message with detailed information

____ It is NOT ok to leave me a message with detailed information

____ It is ok to contact me at my work telephone number, which is _____

____ It is ok to leave me a message with detailed information at work

____ It is NOT ok to leave me a message with detailed information at work

____ It is ok to leave a call back number ONLY at my work number

I AUTHORIZE YOU TO DISCUSS MY MEDICAL HISTORY AND RELEASE ANY AND ALL MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS: (fill in all that apply)

____ My spouse, whose name is: _____ phone: _____

____ My parents, whose names are: _____ phone: _____

____ No one other than myself

____ Other, _____ relationship _____ phone: _____

Patient Signature:_____ Date:_____

Printed name: _____

Date of Birth: _____

Name of legal guardian/caretaker: _____

Martin Reinke, M.D.

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817-310-6080-phone
817-310-6014-fax

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We do not create or manage a hospital directory.

We will not contact you for fundraising efforts.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

September 20, 2013

This Notice of Privacy Practices applies to the following organizations.

None.

Privacy Official: Barbara Stuehm ,817-310-6080 ,martin_reinke@yahoo.com